nately constipated. A diagnosis of local peritonitis from gastric ulceration was made and adhesion interfering with bowel action was suspected. Any form of operation was declined. The patient complained bitterly of a constant heavy feeling in the abdomen. Some relief would occasionally be experienced if gas could be passed per rectum, which took place rarely, or if belching would take place. The pain was felt most just above the umbilicus, although occasionally directly under the sternum. There was no pain or tenderness along the spine. The supraclavicular glands were not swollen, and there was at no time edema of the ankles. Liquid food was taken, but its ingestion was followed by immediate pain. The stomach tube was resolutely declined until a few days later, when he began to vomit, when it was passed once and the stomach washed out, but it caused so much distress that it could not be repeated. The washings contained masses of dark colored mucus, which reacted positively to the guaiac test for blood pigment. The vomitus of the patient consisted at first of the food taken, mixed with mucus, and it contained lactic acid and some free Hcl. No blood was found. The patient began to fail rapidly in strength and weight, to have increasing difficulty with constipation, to vomit more and to have constant pain or heaviness in the abdomen. A loop of bowel became distended with gas and stood out clearly on the left side of the abdomen. A gastric carcinoma with peritonitis at its base was now diagnosed. A week later dark-reddish fluid giving a positive guaiac test was vomited. A small bowel movement of almost pure pus and mucus was passed, and after it the bowels moved more freely. The distension of the abdomen became more marked, and there was flatness on both flanks and the lower portion. The kidneys continued to secrete a small amount of normal urine. The breath became very foul. Large amounts of morphin were required to give any comfort. The patient began to hiccough, the fluid increased in the abdomen, there was occasional vomiting of very foul smelling, bloody fluid, and only two weeks after the patient was first seen and eight weeks after first symptoms complained of, he died, apparently from exhaustion. Upon autopsy, the body, except for the abdomen, was that of a healthy, powerful man. The peritoneal cavity contained about two gallons of clear fluid. The omentum and mesentery were thickened and retracted and the peritoneal surface was studded throughout with small masses from a pin-head size to that of a half pea. The transverse colon was attached to the stomach and the whole colon filled with dark blood. The small intestine was distended with gas, but contained no blood. Upon opening the stomach a foul round ulcerating area about two inches by two inches upon a thick carcinomatous base was found. Adhesion bands extended in various directions in the peritoneal cavity and the bowel seemed encroached upon by some of these, but careful examination did not determine any point of marked obstruction, and I do not know whether the constipation noted was due to adhesions, to the abscess from which pus drained, or to peritonitis. Apparently death was hastened by the loss of the blood found in the large bowel. The pus obtained at one time from the stool was probably from a small abscess rupturing into the colon, as it was not admixed with fecal material.

In this case, while there was some evidence of intestinal obstruction, at no time was malignant growth of the bowel itself suspected, the symptoms and signs pointing to the stomach and peritoneum.

In looking at all four cases together it is clear that a fairly correct diagnosis of the causes and location of the disease was made in three cases, where there was some bowel obstruction, but in the one with multiple growths of the small intestine it was not even suspected. Here the abdominal wall was thick and fat and no tumor mass large or small was felt except that of the appendix, and all attention was directed to that.

The differentiation of chronic bowel stenosis or occlusion due to new growth and the interference with peristalsis in chronic peritonitis is full of interest, and in distinguishing the two, where no tumor mass is found, after examining all possible hernial openings and the rectum we should seek for visible peristalsis as a sign of occlusion and pronounced tenderness on pressure as indicative of peritonitis. The chronic stenosis and obstruction are readily separated from the acute by the irregular symptoms, moderate abdominal pain, slight vomiting, history of constipation and spurious diarrhea, the loud gurgling intestinal sounds, the history of coated tongue, and normal temperature, and usual uneven distension of the abdomen of the chronic form and the more violent pain, severe vomiting, and collapse generally present in the acute form.

From the cases reported it would seem evident that the localization of some of the growths of the intestine is possible, particularly if in the rectum or lower part of the duodenum. In diagnosing stenosis of the small bowel a few points are helpful. Rectal irrigation will often empty the colon, and with remaining abdominal distension and changes in shape of abdomen from distended loops of intestine will often point to the small bowel as the seat of obstruction. Pain is such a common functional symptom that unless it is constantly felt by the patient and tender to pressure at a given point it is not of much value, although it usually comes earlier as a symptom of small bowel involvement than of large. Indicanuria has been urged as more indicative of small bowel stenosis than of large, when present in a suspected case. Examination of the stool, aside from the presence of bile, can be of little value in localizing the point and cause of obstruction, but of course the presence of blood and mucus may throw light on the case in general. Vomiting is usually more violent and severe and more readily stercoraceous in small intestinal occlusion than in large. But the symptoms are so interchangeable and variable that the accurate localization and cause of a chronic stenosis of the bowel, except in the rectum and duodenum, is probably, as Nothnagel has said, the most difficult task of anatomic diagnosis.

SAN FRANCISCO SOCIETY OF EYE, EAR, NOSE AND THROAT SURGEONS.

THE TREATMENT OF SYPHILIS OF THE EAR.

By M. W. FREDRICK, M. D., San Francisco.

In marked contrast to the large number of cases of syphilis occurring in the practice of eye, nose and throat diseases the number of ear affections traceable to syphilis is very small. In fact, some of the older writers were emphatic in the statement that lesions

characteristic of syphilis are never observed in the middle ear or tympanic membrane. The whole subject of syphilis of the ear was, until recently, treated in a very superficial manner in the text books, only a few pages being devoted to it, and some of the books entirely ignoring the involvement of the ear in congenital syphilis. The journals rarely contained anything on the subject. Of late, however, a change has taken place, and both in the journals and text books the subject is receiving the attention which it so well deserves. There is no doubt in my mind that if the attention of the physicians were called to this topic the number of cases observed and recorded would be far greater than at present.

Beginning with acquired syphilis I shall not devote any time to the affections of the external ear, as these belong to the realm of dermatology. I wish to mention only that broad condylomata of the external canal occur in a small number of cases and may be mistaken for furuncles; or, when they assume the appearance of the reddish, wart-like excrescences so often seen about the anus, they may be mistaken for granulations due to carious bone in or about the middle ear. As a rule there are other syphilitic manifestations to help establish the diagnosis, and the treatment consists, aside from the constitutional treatment, in the removal of the excrescences, either by snaring or abscission, and touching with silver nitrate; or in dusting in calomel, iodoform, washing with weak solution of silver nitrate or other adstringents. Syphilitic ulcers of the canal, an extremely rare condition, may be mistaken for broken down furuncles, a mistake against which the swelling of the neighboring glands should be a safeguard.

The only primary sore which I will speak of is the one having its seat at the pharyngeal mouth of the eustachian tube. This chancre was not of infrequent occurrence formerly, but now occurs much less often. The greater care taken to keep our instruments aseptic, and the practice of many otologists to reserve a catheter for each patient, has made this regrettable accident a rarity. The site of the lesion makes it difficult of detection and treatment. As a rule the swelling of the glands is what draws attention to the lesion. The treatment consists in cleansing the sore by sprays through the nose or used postnasally, insufflation of iodol or iodoform, and in touching with acid nitrate of mercury or other caustics, should the sore be indolent. As a rule there is no pain attached to this lesion.

Mucous patches and ulcers resulting from their breaking down are not uncommon around the mouth of the eustachian tube, and the pain from these is often severe, giving rise to so-called neuralgia of the middle ear. The ear in these cases often presents a normal appearance, hence the use of the term neuralgia, a poor subterfuge to conceal ignorance. Local anesthetics applied to the pharygeal lesions will stop the pain in the ear; cocain, eucain, gargles with potassium bromide or antipyrin are amongst the best things to be used in this direction. For the healing of these lesions cleansing with sprays, the topical application of weak solutions of corrosive sublimate of silver nitrate, and inflation of the middle ear are the means to be used.

Much more intense than in the preceding cases is the pain in ear and head due to broken down gummata in the region of the tubal mouth, and I have known patients to be treated with all sorts of anti-neuralgic remedies when an examination with the rhinoscopic mirror would have revealed the seat of the trouble. The treatment of these ulcers is much the same as that of the more shallow variety of the secondary stage, but the potassium preparations, either by mouth or by injection, should be pushed vigorously.

The local treatment of the catarrhal affections of the middle ear is much the same as that in the non-syphilitic cases. The difference between the non-syphilitic and the syphilitic forms lies in the fact that in the latter there is an early implication of the inner ear, so that we have to resort to energetic anti-syphilitic treatment; mercury either in the form of inunction or injections, potassium iodid, and sweating with pilocarpin. On the whole it will be found, however, that the prognosis in the chronic catarrhal inflammations of the middle ear due to syphilis is worse than in the ordinary forms, and that is, unfortunately, bad enough.

While purulent inflammation of the middle ear due to syphilis has been seen by few and denied by many, there is no doubt in my mind that in time we shall come to recognize this condition more frequently than we do at present. There is no good reason to assume that syphilitic affections should act differently in spreading up the eustachian tube from what other inflammatory purulent conditions of the pharynx do. One distinguishing feature of this purulent otitis media is the occurrence of a second perforation in the drum membrane without any pressure behind the drum. This process Buck compares to the melting process seen in the soft palate. It is as a sequela to this purulent otitis media that we encounter the ulcers and condylomata of the external canal already mentioned. Necrosis of the bone occurs with about the same frequency in this condition as in the non-syphilitic variety.

The local treatment is, again, the same as that in non-syphilitic cases. Cleanliness, removal of granulations, the use of antiseptic powders, and of astringents in the later stages, will effect a cure if begun early and if the patient is in otherwise reasonably sound health, or can be put in that condition by the use of tonics and feeding. The anti-syphilitic treatment should be early and energetic for the reason already pointed out.

The affections of the innear ear often come on very suddenly, and again are insidious. When the onset is sudden a vigorous antiluetic treatment will often restore the hearing. One should not hesitate to use large doses, and the use of pilocarpin to produce profuse sweating is one of the aids towards restoration of function. The subcutaneous injection of 4 to 12 drops of a 2% solution pilocarpin muriate every day for a week is the prescription given by Politzer.

When the onset is slow the prognosis is extremely

bad, and therapy of any kind is of little avail. However, a vigorous anti-syphilitic treatment, combined with a generous diet and tonics, is worth trying, although nothing can be promised. In subjects who have not had any anti-syphilitic treatment for a long time, and in those who were insufficiently treated at the outset, one can often accomplish more in these late stages by the use of mercury than by the use of the iodides. In using inunctions I have of late given preference to the ointment made with vasogen, as I think it is absorbed best in that vehicle, and is much neater than the ordinary gray ointment. The syrup of hydriodic acid is a very agreeable way of exhibiting iodid, but I rather prefer in cases calling for vigorous treatment the old solution of potassium iodid.

In congenital syphilis diseases of the middle ear are not uncommon, and have nothing to distinguish them from the same conditions in children. Death often intervenes from marasmus before the local condition can be improved. The constitutional treatment consists, according to Hutchinson, in the rubbing of mercurial ointment into the soles and palms, no other remedy being of value.

Between the ages of 5 and 25, after a parynchematous keratitis or a painless swelling of a joint, the hearing is often suddenly lost. In some of these cases there had been a gradual diminution in hearing preceding this sudden deafness. In these cases treatment, as a rule, avails nothing. The only hope of betterment lies in putting the patient to bed and inducing ptyalism as soon as possible. Flyblisters behind the ears, blowing iodin vapors into the tympanic cavity, scruple doses of hydrochlorate of ammonia (Hinton), have been tried with little or no results.

DISCUSSION.

Dr. D. W. Montgomery: The treatment of syphilis is always an interesting subject, and more especially so when it involves such important organs as the eye and the ear. I see very few of these cases, excepting as iritis and keratitis occuring as an incident during syphilis in the seconldary stage. I recall now a very interesting case of syphilis affecting the internal ear seen with Dr. Barkan and Dr. Richter, and some time previous to that I had under my charge in the San Francisco Polyclinic an interesting case of Meniere's disease, occuring during the course of early constitutional syphilis. For a long time he could hardly make his way along the streets because of dizziness, but finally he became entirely well so as to be able to walk with security on an elevated narrow pathway.

The late Dr. J. F. Morse used frequently to insist on the importance of elimination in the treatment of syphilis. I do not think there is any doubt of the importance of this. In using either of the specifics for syphilis the mode of introduction of the drug is important, but the mode and the facility of its exit is equally important. The elimination of the drug being of such weight, much circumspection should be exercised in coincidently using a remedy like opium that interferes with elimination. I rarely use either opium or morphin when giving mercury. And this is a point that brings into relief Dr. Fredrick's remarks in regard to pilocarpin. I should think that pilocarpin might act favorably in the treatment of syphilis, because of its sudorific effect. Hot baths have long been advised in syphilis, and probably their beneficial influence is also due to their causing free sweating and so effecting elimination.

As for the form in which mercury should be given, I think mercurial inunctions is easily the best. During a trip I took last summer I rarely heard inunctions mentioned in any of the clinics visited. One could frequently see, however, the dark stains of this treatment on the patient's skin. On the other hand, I heard a good deal about atoxyl as given for syphilis. Inunctions were so self-evidently good and so well tried out that no one needed to speak of them, while on the other hand atoxyl was new and had the freshness of novelty, even though on trial it might prove to be of little value.

As for intramuscular injections, I saw the sozoiodolate of mercury used only in one clinic during my trip, and I don't think it has any particular value over other preparations of mercury. The salicylate of mercury is a great favorite as an intramuscular injection, and it certainly acts wonderfully well. Gray oil I rarely use, and calomel is atrociously painful. Bichloride of mercury injections are good, but frequently leave marked and long enduring indurations. I saw a woman a short time ago whom I had treated about five years previously with bichloride of mercury injections. She was under my care for about one year, taking three injections a week. Her buttocks are still dimpled with deep cicatricial contractions as a result of this treatment.

In conclusion, I don't think I can insist too much on elimination as a factor in the treatment of sypnilis. I do not wish to be misunderstood in regard to my attitude about giving mercury by the mouth. Without wishing in the least to minimize the excellencies of the inunction method or the methods by intramuscular or intravenous injection, the method of giving mercury by the mouth has its advantages, among them its convenience. It is also effective for the only two cases of syphilitic reinfection that I have ever seen were in men who had been long and steadily treated in the early stages of their first attack by protoiodid of mercury pills given by the mouth. That these men had been infected with syphilis many years previously for the infection for which I attended them admits of no doubt, as in both instances the previous infection had been diagnosed by men of world-wide reputation. To my mind, when a man has so far lost all traces of his disease as even to have lost his immunity against a second attack, it is evident that he should be considered as having been cured from his first attack.

Dr. Garceau: In coming here tonight I feel a little embarrassed, as this is a field far from that of the dermatologist. The work of the dermatologist comes largely under secondary and tertiary cutaneous manifestations of syphilis. In looking over some literature this afternoon I came across a paper on the treatment of syphilis recently published by Dr. George Pernet of London covering the field very widely, and I picked out one of his opening sentences. "If there is a disease about the treatment of which there is a fascinating divergence of opinion, it is syphilis. Ideas and methods regarding this disease vary from not only medical man to medical man, but also from country to country. About one thing every one appears to be quite sure, however, namely, that he knows how to treat syphilis better than any one else." To speak generally on the general treatment of syphilis from the primary, secondary and tertiary forms would occupy a large volume. I think we are all prone to adopt such a method as in our experience over a number of years, or the experience of others, has seemed to give the best results. This divergence of opinion has made me an eclectic. I do not deny that any treatment of syphilis which will destroy the accumulation of spirochatae is a justifiable one, but we must treat the patient from an individual stand-

point, taking into consideration age, weight, occupation, nationality, sex, etc. I agree with Dr. Montgomery that elimination is one of the first principles in the treatment of syphilis. Not only elimination, but also the care of the nervous system. It would be too wide a subject for me to cover tonight about the preference for individual drug. You get all the elimination you desire in the internal administration of mercury. In the treatment of any syphilitic manifestation, I prefer the intermuscular injections of the soluble salts, and my choice is the one per cent solution of the sozoiodolate as prepared by Lenfeld. I have had only one occasion to resort to anything else, and that was in a case of an intense gumma of the brain, and then I did use the Gray oil most effectively. I want to emphasize in closing that experience teaches us all to treat syphilitics from an individual standpoint. Mercury and iodid of potassium, or mercury in any form or iodid of potassium administered in any form whatever have their beneficial effect. Choice of these remedies is gained by experience and knowledge only.

Dr. Krotoszyner: If it is true that there exist many opinions in this society about the treatment of syphilis, it is also true (and I state this fact with some gratification) that the authors of the various papers agree on one point, i. e., the main remedy in the treatment of syphilis is mercury. There only seems to be some divergence of opinion in what manner the drug should be introduced. Right here I wish to state that I am glad to learn from your papers that the internal application of mercury as the only means of treatment is more or less abandoned. For the exclusive internal treatment is only useful in mild cases, while in graver cases of syphilis this mode of treatment has proven to be entirely inefficient. Like Dr. Montgomery, I think our main standby are the inunctions which, if used properly and energetically, will in the great majority of instances give the desired curative results. I insist that well-trained maseurs be employed in applying the inunctions, for I have seen that patients, in the majority of instances, will apply the inunctions carelessly and not spend the necessary time for thorough mercurialization of the skin. In other words, you cannot consistently speak of an inunction cure lege artis unless you are convinced that the inunctions are properly applied. You will see that the majority of European syphilologists favor inunctions, for they generally see good results with this mode of treatment, if properly applied.

I have also had a long experience with soluble mercury salts, especially the bichlorid. I generally inject 1 cc. of a one per cent solution daily, or if the patients cannot come to the office daily I give 1 cc. of a 2 per cent solution every other day. If the patient can stand it (because the bichlorid injections of higher percentage are often very painful) I inject 25 drops of a two per cent solution twice a week. I have noticed that women complain less of pain caused by the bichlorid injections than men. It is possible, though, that this may be due to the fact that inunctions are particularly distasteful to women.

Some ten or fifteen years ago I treated a great many of my patients with the insoluble salts of mercury, especially calomel and salicylate of mercury. The injections, though, are very painful, occasionally an abscess will be noticed, and in a few instances I observed, like others, a severe stomatitis after a repeated calomel injection. Therefore I have more or less abandoned this mode of treatment for the routine work in favor of the sublimate injections which have given me very satisfactory results during the last ten years.

Dr. Kaspar Pischel: Since we have with us tonight men of great experience, I cannot let this opportunity pass without asking some questions for personal information.

How reliable is the diagnosis of syphilis through the use of serum and through the examination for spirochetae?

While Dr. Montgomery has told us that inunctions are the most effective treatment, is it the quickest, or can we get quicker results by intravenous or intramuscular injections? Have any experiments been made in that line? How long should the treatment be continued? When may a man be allowed to marry? What is the difference and what is preferable, potassium iodid, sodium iodid or hydriodic acid?

Dr. Welty: In a discussion of this kind it is very important to know if you are dealing with primary, secondary, or tertiary, manifestations. Practically all of my cases are of the latter. And, according to the recent teachings that I am familiar with, iodid of potassium is the drug on which I have placed reliance, and all of the cases except one have yielded. This case had extensive tertiary syphilis of the larnyx, and it did not yield to this form of treatment, nor did it yield to mercury given by mouth.

Acute syphilis of the ear which comes with secondary affection is amenable to treatment as the doctor has stated, but I have yet to see the case of tertiary manifestations of the labyrinth that has been benefited at all by the administration of mercury or iodid of potassium.

I have never seen a primary, secondary or tertiary affection of the tube. I know it must be very rare. I had two cases of gumma of the septum, that were partially broken down. Iodid of potassium was administered for two weeks, and the case has entirely recovered. In another case of syphilitic granulomata on the floor of the nose, side of the septum and part of the inferior turbinate, after two weeks' administration of the iodid of potassium the granulation was entirely gone.

Another case of syphilis of the larnyx was diagnosed by the healed tertiary affections that had preceded and by the characteristic appearance of the lesions on the vocal cords. This patient could not speak above a whisper when I first saw her. She was given iodide of potassium and inside of ten days she was talking. However, the voice was husky. This huskiness has almost entirely disappeared at the present time, which is about three weeks from the first time I saw her.

In syphilitic gumma of the brain or cord, I have no doubt that the mixed treatment or a concentrated solution of mercury given hypodermically will yield the best results. A decided impression must be made upon the gumma in a very short time, or you will have a pathological degeneration.

Dr. Martin: I feel safe in saying that there is no prescription used so frequently in the treatment of syphilitic affections of the eye, nose and throat as the combination of iodid of potassium and bichlodid of mercury. Teritiary conditions with which we have mostly to deal in these regions as a rule clear up very quickly under this treatment; but I hardly think that the specialist believes that he has effected a cure of other than the local manifestations. When the lesion is deep seated, affecting the optic nerve, retina or choroid, I depend on the use of inunctions followed by a course of pilocarpin sweats as recommended by Burnham of Toronto. For this method of treatment the patient should be under the eye of the physician and in a sanitarium.

Dr. Barkan: As much as we have learned, it strikes me that one point might be made to good advantage, and that is with regard to the relative value of mercurial treatment and that with iodid of potassium. I have long felt that we must rely on mercurial inunctions as the chief agent not only

in the early forms of the disease, but also in the late forms, and I was much pleased to come across an article published lately by Prof. Zeisl, who makes much of that very point. He maintains that mercury is as efficient in the very late forms of syphilis as in the early forms. He strongly advises combining both the mercurv treatment and the treatment with iodid of potassium from the first and carrying it out to the last. I was pleased to know the opinion of a man as he, for I have met with very interesting results in trying to treat these cases of the late forms of the disease, and have succeeded well in forcing the mercurial treatment together with iodid of potassium. Another point which I would like to suggest is that of the application of Zittmann's decoction in the old forms of specific eye affections. An old gentleman who had treated for specific irido-choroidoretinitis in the South with large doses of iodid of potassium did not progress and came up here. I sent him to the hospital, where he was put upon inunctions and daily pilocarpin sweats for four weeks. Yet he did not improve materially until in the fifth or sixth week he commenced drinking Zittmann's decoction, and his sight recovered within about three months entirely. I consider this due to the changing of the condition of the blood and eliminating the syphilitic virus. Zeisl, I will mention again, advises also the hydro-therapy and finally suggests the saodine in preference to the iodid of potassium, for it has no odor and no taste, and produces but rarely the general symptoms of iodin. The case of specific labyrinthitis to which Dr. Montgomery refers was indeed a very interesting one. The woman was about thirty-five. She had been under my care previously for some little ear trouble. This time I was called in to ascertain the significance of a symptom which was quite striking. The patient, soon after going down the chutes one day, suffered from vertigo, noise in her ears and deafness, and became quite prostrated. There was some doubt as to the diagnosis, as the skin lesion pointing to syphilis was rather slight. Inspection of the ear revealed normal conditions. In addition to the deafness and the vertigo present, the diagnosis of specific labyrinthitis was made because of her inability to hear the vibrations of high pitched tuning forks. The last symptom prompted me to believe the trouble to be an acute specific labyrinthian condition. We submitted her to inunctions and pilocarpin sweats, and she had a quick and satisfactory recovery.

Dr. Louis C. Deane: I think I can speak for every member of this society that we are not only honored but pleased at the presence tonight of so many visitors. They are men who have made a life study of syphilis and its treatment, and we have all profited by the remarks heard here tonight. Their remarks have constituted primarily the general treatment of syphilis. I will say for our visitors that I am sure that they have also come to learn something from us with regard to syphilis of the eye.

There is hardly an organ of the body that is more interesting than the eye from a syphilitic pathological standpoint. We have here an organ composed of tissues of the most diverse character, all subject to syphilitic manifestations, with the added advantage that these changes can be accurately observed during life. In the sclera we have a tissue composed of fibrous elements and entirely devoid of blood vessels; adjacent to it the choroid, a tunic composed entirely of blood vessels, and again in contact with it the retina, the most highly organized nervous tissue in the body; all so different in their composition and construction, yet all showing numerous and unmistakable forms of syphilis.

The anterior portions of the eye, such as the clear and bloodless cornea, with the mass of blood vessels and muscular tissue composing the iris and the ciliary processes so frequently participate in general syphilitic infection that manifestations here are quite the rule rather than the exception.

An occulist who has observed carefully the clinical and pathological changes in eye diseases has become, so to say, a syphilographer of no mean proportions.

Regarding local treatment for syphilis of the eye, one interesting exception to the therapy of general syphilis is to be noted; while opium or any of its derivatives are clearly contra-indicated as checking elimination, in the eye we have a morphin derivative in the form of dionine which acts in exactly a contrary way. It is one of the most active lymphagogues imaginable, and in a few minutes after its instillation in the eye, the tissues become markedly oedematous, the lymph thus extracted being gradually carried off by the circulation.

Subconjunctival injection of mercury as practised by Darier of Paris, though criticized by some, has stood the test of a number of years' practice, and the numerous favorable reports gives this method a firm stand as a valuable remedy. A misconception and improper technique in its use, I believe, has led many to abandon it as being too severe in its reaction. It was with much interest that I spent some five weeks with Darier and observed him practice this method in numerous cases. He uses a curved needle and thrusts it directly into the postocular tissue through the superior conjunctival fornix, not under the ocular conjunctiva, as generally practiced. The reaction is thus lessened. Mercury in the form of the cyanid he recommends for this purpose.

While speaking of Darier, I must also mention his intravenous injections of mercury. While not generally practiced, one leaves him with the impression that it is a method that more will be heard from in the future. He has used it thousands of times with apparently no untoward results as to the method of application, no pain following or localized areas to remind one in years to come of the injection. He places no importance upon the injection of air into the vein, never taking the trouble to remove it from the syringe.

As to the local application of the various mercurial ointments commonly used in eye diseases, it is hard to state their exact importance as a specific, as their effect upon some nonsyphilitic lesions is as pronounced. Suffice it to say that we rely upon them in syphilitic affections of the cornea and sclera, and whether they act as a local irritant and absorbent or as a mercurial specific, the results are in many cases most favorable.

When dusting calomel into the eye one is compelled to believe that it is the mercury that shows its influence, for other drugs similarly used have not proven as efficacious. It has been said that thiosinamine is to the eye, when applied locally in the form of a salve, what the iodides are when administered internally. This has been hailed with especial favor by the occulist as locally iodin remedies have not proven successful.

Dr. Nagel: I have been pleased to hear several syphilidologists speak so favorably of inunctions. It is certainly the stand taken by some of the foremost clinicians of Germany. It is largely the belief among ophthalmologists that in inunctions we are using the strongest absorbent at our command—irrespective of lues. I think I am correct in saying the former belief, that the intramuscular injections are more accurate, is largely looked upon as fallacious now. I think it is principally due to the want of measuring accurately how much Hg is eliminated that investigators have come to that conclusion. With regard to subconjunctival injections of mercurial solutions with a view for topical effects, I should like to remind the society that, according to experiments by Vogel at our clinic in Bern, Hg

does not enter the eye. So it seems but rational that such a mode has, as a matter of fact, largely been abandoned. One should also always remember the observation of Fuchs, i. e., that if such injections are made too close to the limbus we are apt to severely injure the cornea. Regarding subconjunctival injections of saline solutions, I should like to mention the method practiced during my service in Bern, consisting in doing a Keratomy along with the injection. It has been proved experimentally that the sudden depletion of the anterior chamber acts as a strong stimulant for nutritive changes in the uveal tract, and combining a keratomy with subconjunctival injections of saline solution we found to be a very efficient way of favorably influencing a number of graver fundus affections. The use of the guarded lance renders the operation safe and rather unimportant, with practically no risk of iris-prolaps or adhesions.

EVILS OF THE LODGE PRACTICE SYSTEM.*

By REXWALD BROWN, M. D., Santa Barbara, Cal.

Mr. President and Members of the Santa Barbara County Medical Society: It is far from my purpose tonight to introduce into my remarks anything of bitterness, or to condemn outright with rash statement that particular form of contract medical service known as lodge practise; the subject is too large a one to be viewed from but our standpoint, too complicated a one to be handled harshly. The medical profession is not yet a unit on the value or the perniciousness of lodge practice to society and to the profession. The condition as it exists today is, however, provocative of much discussion throughout the medical world, and efforts toward a solution are read of in almost every reputable medical journal. With constantly increasing volume the flow of opinion is reaching the conviction that the present system of lodge practice is, in the main, dangerous to lodge members and inimical to the welfare of the profession. This last statement expresses my convictions, and I hold to them as I hold to convictions in politics, in religion, in morals, without feeling of animosity toward those who differ with me.

In this age of the world, movement in the social fabric is toward association; most accomplishments, good or bad, affecting greater or lesser divisions of humanity, in the industrial, labor, financial, religious and purely social spheres, are maneuvered to completion through the force of many minds acting in unison. Mutual helpfulness is the guiding motive—the desideratum, the greatest good to the greatest number. This sounds utopian; it isn't though; the innate selfishness of man, singly and in the aggregate, does not suffer annihilation in the momentum of associate action; the conflict for self-aggrandizement, for power, for gain at the expense of others, finds expression within the very center of the charmed circle directing a movement, and the movement itself is scarce likely to take heed of individuals or other movements, which it is to its interests to use or to crush.

Fraternal orders, lodges, clubs, are expressions of our civilization today; they have been evolved from the social aspirations of man, and are associative movements directed primarily toward bringing congenial persons into closer contact for various purposes. In this country, except in very recent years, the chief aims appear to have been the promotion of bon comaraderie, healthful pleasure, intellectual gain, and the institution of financial benefits to members in need through sickness. As such, fraternal orders and lodges have been important factors in social and industrial life, and well deserve their integral part in the body politic.

At the present time, however, the chief aim of many fraternal orders appears to be the exploitation and control of physicians in the interests of the numerical and financial growth of the lodges, and mainly at the expense of the physicians. This, I realize, is a very radical statement, at which vehement exception might be taken, and I shall qualify it. I do not believe this status of affairs to have been intentionally born and fostered; it has been evolved from the sick benefit encumbrances of the lodges, and is altogether an expression of the manner in which expenses incurred by members through the onslaught of disease have been reduced to a minimum. The lodges have had in mind the best possible arrangements for the greatest possible number. The movement concerns itself but little with, and that to flatter, the interests which it uses, and sweeps on regardless, because blind to the dangers which beset its course. I am free to confess, however, that in view of so many lodges having been formed whose only aim appears to be to get medical services cheaply, that I believe unscrupulous men, taking keen advantage of conditions as they are, have found it to their financial advantage to organize lodges, using doctors' services as a magnet to gain members.

The above is an attempt explanatory of the involvement of the medical profession in lodge practise. I admit the explanation is a bit hazy. The problem which confronts us as medical men, however, is not the cause of the existence of the practice; we must concern ourselves with the evils manifested in the workings of the system. And here let me say it will avail us nothing to rail at the lodges for their introduction and management of this practice; they have merely grasped an opportunity. Nor should aught be said in scathing denunciation of the doctors who have lent and are lending their efforts in furtherance of the practice. Let us be just to them; they—most of them—believe fully in the propriety of the system, and in the real good to be accomplished through it. Also many physicians have made a fair competence through their lodge work and have rendered excellent service to patients. They have been and are honest in their convictions of an economic basis for the system.

Yet I think it can unqualifiedly be stated that physicians are wholly responsible for the development and maintenance of the lodge practice conditions as they exist today. As originally evolved and handled, the system seemed to promise well—there

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